Title 25. HEALTH SERVICES
Part I. TEXAS DEPARTMENT OF HEALTH
Chapter 37. MATERNAL AND CHILD HEALTH SERVICES
HEMOPHILIA ASSISTANCE PROGRAM

§37.11. Purpose.

The purpose of these sections is to implement the Hemophilia Assistance Program authorized by Texas Civil Statutes, Article 4477-30. The program of the Texas Department of Health was created by the Legislature to provide financial assistance to persons who are eligible for services. By law, the program shall provide financial assistance for medically eligible persons through approved providers in obtaining blood, blood derivatives and concentrates, and other substances for use in medical or dental facilities or in the home.

§37.112. Definitions.

The following words and terms, when used in these sections, shall have the following meanings, unless the context clearly indicates otherwise:

Act-The Hemophilia Act, Texas Civil Statutes, Article 4477-30.

Active case-All aspects of eligibility have been met. Eligibility continues for a period not to exceed one year's duration, as long as each of the eligibility criteria are met (have Hemophilia and can meet the financial need and residency requirements).

Anniversary date-The day in the year on which initial eligibility was established and from which program restrictions based on 12-month limitation periods will be measured.

Applicant-A person making application for the program, but not currently determined eligible.

Approved providers-Any pharmacy, hospital, blood bank, or pharmaceutical manufacturer or distributer legally doing business in the State of Texas, to the extent that the program has not made binding agreements or contractual arrangements with a limited number of providers for purposes of cost containment or quality assurance.

Commissioner-The commissioner of health.

Department-The Texas Department of Health.

Eligible person-A person who meets all program requirements for eligibility.

Eligibility date-The effective date of initial eligibility for the program, which is:

(A) the date all eligibility requirements were met, or

(B) the date of blood product delivery if all written information to establish eligibility was received in the program within 30 days of that date.

Hemophilia-A human physical condition, characterized by bleeding, resulting from a genetically determined deficiency of a blood coagulation factor or hereditarily resulting in an abnormal or deficient plasma procoagulant.

Legally responsible person(s)-A person(s) who has legal obligation to support the patient, also referred to as parent/guardian/conservator.

Other benefits-Any other resource available to the eligible patient or the legally responsible adult(s), if the patient is legally dependent on someone else, other than a benefit under this Act, to which a person is entitled for payment of the cost of blood, blood derivatives and concentrates, and other substances provided under this Act, including the following:

(A) third party insurance;

(B) personal financial resources;

(C) a legal course of action, settlement, or judgment in behalf of the patient;

(D) coverage by the Texas Department of Health, Crippled Children's Services Program, Title XVIII or Title XIX of the Social Security Act, the Veteran's Administration, Worker's Compensation, or any compulsory employer's insurance program;

(E) a public program created by federal law or state law;

(F) the ordinances or rules of a municipality or political subdivision of the state, except those benefits created by the establishment of a city or county hospital, a joint city-county hospital, a county hospital authority, a hospital district, or the facilities of a publicly supported medical school; or

(G) benefits available from a cause of action for medical expenses to a person applying for or receiving services from the department or a settlement or judgment based on the cause of action if the expenses are related to the need for service provided under this Act.

Patient-An eligible recipient of the Hemophilia Assistance Program, also referred to as eligible person.

Program-The Hemophilia Assistance Program.

State-The State of Texas.

§37.113. Eligibility for Patient Services.

In order for a person to be eligible for the Hemophilia Assistance Program, the person has to meet the medical, financial, and related criteria in this section.

(1) Medical criteria. To be medically eligible for the program, the patient must have been diagnosed as having hemophilia by a physician licensed to practice in Texas.

(2) Financial criteria.

(A) Financial need. Financial need is established on the basis of income and assets which are legally available to the applicant.

(i) Income. The income used to determine eligibility is the gross income of the applicant and those persons who have a legal obligation to provide for the applicant. Income includes earned wages, pensions, or allotments, child support payments, alimony, or any monies received on a regular basis for family support purposes. Verification of income will be required as set out in § 37.115 of this title (relating to Application Process).

(ii) Priority level based on federal poverty guidelines. Income guidelines are based on percentages of the current federal poverty guidelines and may be adjusted by the program with the consent of the commissioner to meet budgetary limitations. Coverage is based by program priority on percentages of Federal Poverty Guidelines. Income guidelines are maintained on a current basis and are adopted by reference in §37.125 of this title (relating to Income Guidelines). The program will adjust priority levels depending on available funds. Priority levels are as follows.

PROGRAM PRIORITIES BASED ON FEDERAL POVERTY INCOME GUIDELINES

Priority 1--100% or below

Priority 2--101% to 115%

Priority 3--116% to 130%

Priority 4--131% to 145%

Priority 5--146% to 160%

Priority 6--161% to 185%

Priority 7--186% to 200%

Priority 8--201% to 215%

Priority 9--216% to 230%

Priority 10--231% to 245%

(iii) Assets. Assets legally owned by or available to the applicant must be considered as a source of support to provide services for the applicant. Assets include such items as savings, real property other than a homestead, stocks, bonds, mutual or trust funds, IRAs, etc. Exemptions include a homestead (or a farm homestead of not over 200 acres); one automobile for an individual/two for a two adult family. Total assets are limited to a percentage of the amounts established for Supplemental Security Income (SSI) eligibility.

(I) The program will adjust the percentages by priority levels depending on available funds, as follows.

PRIORITY LEVELS FOR TOTAL ASSETS

Priority 1--100% or below of SSI limits

Priority 2--101% to 150% of SSI limits

Priority 3--151% to 200% of SSI limits

Priority 4--201% to 250% of SSI limits

(II) The SSI asset limitations are as follows.

Supplemental Security Income (SSI) Asset Limitations

Effective Date	One Parent Family (or Single Adult)	Two Parent Family
1185	$1,600	$2,400
1186	1,700	2,550
1187	1,800	2,700
1188	1,900	2,850
1189	2,000	3,000

(B) Program coverage.

(i) If the factors considered for financial eligibility are within program guidelines, the eligible person will be allowed coverage as defined by the program. Items covered may include blood, blood derivatives, or manufactured pharmaceutical products.

(ii) For all blood products covered by the program, program payment is considered to be payment in full.

(3) Other benefits available. Any other resource available to the eligible person, or the parent/guardian/conservator must be utilized prior to the use of program funds. This includes benefits from a legal cause of action, settlement, or judgment in behalf of the patient, as well as personal financial resources and third party insurance, or Crippled Children's Services Program coverage.

(4) Health insurance. All health insurance policies held by the applicant and/or family must be listed on the application. If insurance eligibility was effective prior to program eligibility, premium payments on individual or group health insurance must continue. If insurance cannot be maintained:

(A) verification of uninsurability from the carrier or the employer must be provided to the program; or

(B) verification of loss of employment and/or inability to make premium payments must be provided.

(5) Residency.

(A) The person must be a bona fide resident of Texas. A bona fide resident means a person who:

(i) is physically present within the geographic boundaries of the state;

(ii) has an intent to remain within the state, whether permanently or for an indefinite period;

(iii) actually maintains an abode within the state (i.e., house or apartment, not merely a post office box);

(iv) does not claim residency in any other state or country;

(v) is a minor child residing in Texas and his/her parent(s) or a conservator or the guardian of the child's person is a bona fide resident; or

(vi) is a person residing in Texas who is the legal dependent spouse of

a bona fide resident; or

(vii) is an adult residing in Texas and his/her legal guardian is a bona fide resident.

(B) Verification of residency will be requested in the form of a valid driver's license, voter registration, rent or utility receipts for two months prior to the date of application, school records, or other proof of residency if determined valid by the program.

(6) Determination of eligibility.

(A) The final determination of eligibility is made by the program using the information provided by the application. The program may request verification of any information given to establish eligibility, but at a minimum will require that documentation of income and residency be submitted with the application.

(B) Eligibility criteria are:

(i) diagnosis of hemophilia;

(ii) financial need; and

(iii) residency.

(C) The person's case is considered to be active when all aspects of eligibility have been met and continues for a period not to exceed one year's duration, as long as each of the eligibility criteria in subparagraph (B) of this paragraph are met. The program will respond in writing within 15 days after the application is received regarding eligibility status.

(D) To be medically eligible, a person must have the medical condition of hemophilia as certified by a physician licensed to practice in Texas.

(E) At the time initial eligibility is established, an eligibility date will be determined and entered into the program record. The eligibility date assigned will be:

(i) the date all requirements for eligibility were met; or

(ii) the date of blood product delivery if the program was notified of the need for an application to be made, and if all written information to establish eligibility was received within 30 days of that date.

(7) Determination of continuing eligibility. Eligibility is established for a maximum of one year. Financial eligibility must be re-established on at least an annual basis.

(A) To maintain eligibility for program benefits the person must:

(i) continue to reside in the state;

(ii) be in financial need as defined by the program;

(iii) continue health insurance premiums, if applicable;

(iv) apprise the program within 30 days of changes in the following:

(I) permanent home address;

(II) insurance coverage;

(III) employment;

(IV) income;

(V) assets.

(B) The program may request current information when there is indication of a change of family circumstances, but no less often than once a year.

(C) Verification of income and residency will be required.

(D) If insurance eligibility was established prior to program eligibility, premium payments on individual or group health insurance must continue. Non-compliance with this requirement will result in the termination of program benefits. If the person is considered uninsurable, verification of denial of coverage will be required from the carrier or the employer. If the family is unable to continue premium payments, verification of unemployment or financial inability to continue premium payments will be required by the program.

§37.114. Services Provided to Patients.

The program provides no direct services but utilizes a reimbursement process through authorization of purchase of blood products delivered by program approved providers.

(1) Types of assistance. Payment may be made to approved providers for blood, blood derivatives and concentrates, and other substances for the treatment of hemophilia, prescribed by any physician licensed to practice in Texas. The provider must submit proof of receipt by the patient and a copy of the physician's prescription with the voucher.

(2) Program coverage. To be eligible for program coverage a person must meet all

eligibility requirements of the program and be at or below the percentage of the federal poverty guidelines in effect for the program according to income priority levels. Coverage may be limited or restricted if necessary to remain within available funding. The program will notify patients and providers of the extent of coverage when eligibility is determined and when authorization is requested.

(3) Limitations. The program may limit or restrict services to remain within available funding and to provide effective and efficient administration. If funding shortages occur, priority will be given to those persons already eligible and receiving services over those making initial application. The eligibility date will be used to make this determination. If cutbacks in services are required, parties directly affected will be given a minimum of 30 days notice. Services may also be limited by the following means (not listed by priority):

(A) changes in income priority levels;
(B) limits on expenditures - by case, by annual cost.

§37.115. Application Process.

(a) Availability of application. Applications are available to anyone seeking assistance from the program. Application forms may be obtained from any local or regional health department or the program office in Austin. The completed application form is sent to the program for eligibility determination. To be considered by the program, the application must be made on the department form entitled Hemophilia Assistance Program application, shown to be effective after September 1, 1985. Forms utilized prior to September 1985 may be accepted by the program through January 1, 1986, provided documentation of income and residency is attached to the application. The person is considered to be an applicant from the time the program is notified (in writing or by telephone) that the person wishes to make application until the determination of eligibility is made by the program. The program will respond in writing within 15 working days after the application is received by the program regarding eligibility status. Applications will be considered:

(1) denied if eligibility requirements are not met;

(2) incomplete if sufficient family information is not provided;

(3) pending if medical information is not yet available;

(4) approved if all criteria are met.

(b) Family circumstances.

(1) The applicant or parent/guardian/conservator must submit a properly completed, signed application form to the program. Any documentation requested on the

application must be attached to the form or it will be returned as incomplete.

(2) Information required includes, but is not limited to:

(A) data about the applicant-name, present location, date of birth, and place of birth, social security number, if applicable, and whether the applicant is currently eligible for Medicaid and/or Medicare;

(B) data about the applicant's legally responsible person(s) (if applicable) - name, relationship, present address and permanent address, telephone, whether a resident of the state (requires verification);

(C) health insurance policies providing coverage for the applicant - insurer, policy number, group number, certificate number, and amount of monthly premium;

(D) income of the applicant or legally responsible person(s) (requires verification);

(E) assets of the applicant or legally responsible person(s) - description, value, monthly income available;

(F) other members of the household - name, relationship, age;

(G) other benefits available to the family or applicant.

(3) The application is considered incomplete for any of the following reasons:

(A) failure to provide information as requested on the form;

(B) lack of supporting documents, as requested on the form (i.e., income, residency, etc.);

(C) omission of signature on the application of parent/guardian/conservator or the adult applicant.

(c) Medical information. In order to determine medical eligibility, a statement by a physician licensed to practice in Texas must be sent to the program. The physician must provide at least the following:

(1) applicant's name, current address, and date of birth;

(2) diagnosis;

(3) blood product needed, and quantity required (units).

(d) Emergency situations. Emergency situations are treated as any other request and notification must be received within five working days of emergency delivery of blood product. Eligibility must be established before any payment for services can be made; the program must receive a completed application no later than 30 days after the date of blood product delivery. Failure to comply with this 30-day deadline will forfeit the provider's and patient's/applicant's right to any claim for payment.

(e) Verification. The program may request verification of any information given to establish eligibility. This may include more documentation than required on the application if there is incomplete, inadequate, or conflicting information provided. Verification of income, assets, and residency is required as a minimum. Any application that is not accompanied by appropriate documentation will be returned to the sender as an incomplete application. The following information is required.

(1) Residency. Verification of Texas residency must be attached to the application and may be in the form of a copy of one of the following:

(A) a valid driver's license;

(B) voter registration;

(C) rent or utility receipts for two months prior to the month of application;

(D) school records; or

(E) other documents of proof of residency if considered valid by the program.

(2) Income/assets.

(A) All income of the applicant and/or legally responsible person(s) must be verified in at least one of the following ways:

(i) copy of the most recent pay check;

(ii) copy of the most recent pay check stub/monthly employee earnings statement;

(iii) employer's written verification of gross monthly income;

(iv) pension/allotment award letters;

(v) Internal Revenue Service Form 1040 and supporting schedules for the most recently completed year. The program may require submission of this item to verify income and assets;

(vi) other documents of proof of income if considered valid by the program.

(B) If the responsible person(s) is unemployed, a statement of termination from the employer or evidence of Texas Unemployment Insurance enrollment is required.

(C) If the applicant can be confirmed as eligible for Medicaid or food stamps, no verification of income is required.

(D) The program will request current information on family circumstances (see subsection (b) of this section) on an annual basis or at any time there appears to have been a change that would affect eligibility status.

(f) Notification of acceptance. Notification of eligibility status will be mailed within 15 working days after the application has been received by the program and any limitations or restrictions of services will be explained. Any questions regarding coverage should be addressed to the program and not the provider. Incomplete applications will be returned to the applicant.

(g) Denial. The denial of any application to the program will be in writing and will include the reason(s) for such denial. The applicant has the right of administrative review and a due process hearing as set out in § 37.124 of this title (relating to Appeals, Confidentiality, Gifts, and Nondiscrimination).

(h) Reapplication. Any person has the right to reapply for program coverage at any time or when there is a change of situation. An updated application must be received by the program on each patient at least once every 12 months so that eligibility can be redetermined.

§37.116. Authorization of Blood Product Purchases.

(a) Types of authorization.

(1) Standard authorization. Authorization is the program's method of approving the payment for blood products for an active case. If a purchase is authorized, payment is guaranteed to the provider if the purchase is not covered by a third party resource. A request for authorization may be received by telephone or in writing prior to the date of purchase, but must be received within five working days of the purchase date. The program will not pay for any blood product provided more than five working days prior to receipt of notification. All

conditions of eligibility must be met. These conditions include a completed application, current and sufficient financial information, current and sufficient medical information, and determination by the program that the applicant is eligible.

(2) Conditional authorization.

(A) A conditional authorization is the program's method of approving payment on a conditional basis when there is insufficient information available for the program to determine eligibility or the need for blood products. The program will not pay for any blood products provided more than five working days prior to receipt of notification. Conditional authorization will be used under the following circumstances:

(i) when a blood product needs to be provided and eligibility status has not been determined;

(ii) when financial information on an approved patient needs updating; and/or

(iii) when the necessity for a blood product needs written documentation.

(B) Notification of conditional authorization will be provided in writing to providers with the understanding that the authorization will be honored by the program only if all information needed to establish or confirm eligibility or information to justify the need for a blood product is received by the program within 30 days of the date the blood product was provided, and if all conditions of eligibility are met. The notification letter will include those items needed by the program to remove the conditional status. If the information is received within the time allowed, a voucher will be issued to the provider. Conditional authorizations will be canceled after the 30-day deadline if the information is not received.

(b) Third party reimbursement. Under the provisions of the law, any private or public medical insurance or other benefits available to the patient, including the Texas Department of Health's Crippled Children's Services Program, must be utilized prior to the use of program funds.

(1) Any health insurance policies that provide coverage to the applicant/patient must be utilized before the program can be of assistance. Providers must request authorization of purchase of blood product but must bill private insurance to determine the amount of coverage available prior to submitting any claim to the program for payment. Third party explanation of benefits (EOBs) must accompany any claim sent to the program for payment. If a claim is rejected by a third party, the provider may bill the program if the purchase was authorized, and if the rejection letter or EOB is received by the program within 30 days of the date of the rejection, but no later than 180 days from the date of product delivery. Claims

rejected by Medicaid or any private insurance on the basis of late filing will not be considered for payment by the program.

(2) The program will not supplement any Medicaid or Medicare payments; however, purchases beyond Medicaid or Medicare coverage can be provided.

(3) The program will not pay any claim rejected by Medicaid or Medicare on the basis of lack of medical justification.

(c) Limitations. The program may limit or restrict purchases to remain within available funding and to provide effective and efficient administration. The program may establish priorities for budgetary reasons. Purchases may be limited in the following ways (not listed by priority):

(1) changes in income guidelines;

(2) limit of expenditure by case of annual cost.

§37.117. Denial/Modification/Suspension/Termination of Program Benefits.

(a) Reasons. Any person requesting or receiving benefits from the program may be notified that such benefits may be denied, modified, suspended, or terminated if:

(1) application information is erroneous or falsified;
(2) the person is no longer a resident of Texas;

(3) pertinent information is not provided when requested;

(4) obligated reimbursement to the program is not provided. (Any person or persons who have a legal obligation to support the patient and have received third party or liability payments must reimburse the department by lump sum payment or, at the department's discretion, in monthly installments);

(5) program funds are reduced or curtailed.

(b) Procedure. The program will notify the parent/guardian/conservator or the patient of the action taken and the reasons for such action in writing. The right of appeal is available as stated in § 37.124 of this title (relating to Appeals, Confidentiality, Gifts, and Nondiscrimination).

§37.118. Rights and Responsibilities of Parents/Guardian/Conservator or the Adult Patient.

(a) Rights. The parent/guardian/conservator or the adult patient shall have the right:

(1) to apply for eligibility determination;

(2) of notification of modification, suspension, or termination of service;

(3) to refuse entry into the home to any employee, agent, or representative of the department;

(4) to appeal program decisions within 10 working days of the date of written notification of program decisions.

(b) Responsibilities. The parent/guardian/conservator or patient shall have the responsibility:

(1) to provide accurate information regarding any change of circumstance which might affect eligibility, within 30 days of such change;

(2) to reimburse the program if third party payments are made directly to the patient or guardian/conservator for blood products purchased by the program;

(3) to consult with the provider regarding authorization of blood product purchases from the program prior to product delivery;

(4) to utilize insurance and other assets and to inform providers of such benefits/assets;

(5) to notify the program of any other benefits available to the patient at the time of application or thereafter.

§37.119. Providers.

(a) Providers must request authorization in specific terms in order for the program to determine cost and encumber adequate funds for payment of blood products so that provider payment can be assured.

(b) The law specifies that payment of program benefits are secondary to other public and private health insurance programs. Providers must agree to utilize all third party resources available to the patient, including Medicaid or Medicare, prior to requesting payment.

(c) Overpayments made in behalf of patients to providers must be reimbursed to the department by lump sum payment or, at the discretion of the department, in monthly installments or out of current claims due to be paid the provider.

(d) Approved providers must agree to abide by program rules and regulations, to accept program fees as payment in full, and not to discriminate against patients on the basis of insurance, Medicaid, or Medicare status.

(e) Any provider may withdraw from program participation at any time by notifying the program in writing of its desire to do so.

(f) The program may terminate doing business with any provider for due cause. The provider submitting false or fraudulent claims or failing to provide and maintain quality services or medically acceptable standards is subject to review, fraud referral, and/or administrative sanctions.

(g) A due process hearing is available to any provider for the resolution of conflict between the program and the provider.

§37.120. Contracts and Written Agreements.

In order to conserve funds, assure quality, and effectively administer the program, the program may establish agreements with a selected list of providers or contract on a lowest and best bid basis for the provision of blood products.

§37.121. Payment of Services.

No payment will be made for blood product purchases not authorized by the program except as indicated in paragraph (6) of this section. Payment for any purchase authorized by the program may be made only after the delivery of the blood product. If a purchase has been authorized by the program, the family must not be billed for the purchase or be required to make a pre-payment or deposit. Providers must agree to accept established fees as payment in full although such fees may be below usual and customary charges.

(1) Claims payment, denial, rejection. All payments made in behalf of a recipient will be for claims received by the program within 90 days of the date of product delivery, or the latter date shown on the program voucher (90-day filing deadline), and/or within the submission deadlines listed in subparagraphs (B) and (C) of this paragraph. Claims will either be paid, denied, or rejected, generally within 60 days of receipt by the program.

(A) Claims will be paid if submitted on the program approved voucher, if authorized, and if required documentation is received with the voucher.

(B) Denied claims are claims which are incomplete, submitted on the wrong form, or contain inaccurate information when originally submitted.

(i) Payment may be made if the provider corrections are accomplished and the claim is returned to the program within 30 days from the program's notice of denial or within the initial 90-day filing deadline, whichever is later.

(ii) If the claim is incomplete because it lacks other third party explanation of benefits (EOB), payment may be made if the original claim and completed EOBs are received by the program within 30 days from the date of the third party EOB, but no later than 180 days from the date of product delivery.

(iii) Claims that have been denied in error by the program may be reconsidered for payment if the claims, with the error identified, are returned to the program within 30 days of the date of the denial notice, or within the initial 90-day filing deadline, whichever is later.

(iv) Claims that have been denied and are resubmitted for payment must be corrected and be accompanied by a copy of the program notice of denial. Corrections must be made to the original voucher (claim) if at all possible. If a new voucher is submitted, the original claim form must accompany the new voucher. Additional purchases will not be considered for payment on a resubmitted claim.

(C) Rejected claims are claims which fail to meet the filing deadline or are for ineligible recipients.

(i) Claims which have been rejected in error by the program may be reconsidered for payment if the claims, with the error identified, are returned to the program within 30 days of the date of the rejection notice, or within the initial 90-day filing deadline, whichever is later.

(ii) Claims which have been rejected but filed within the 90-day period, if resubmitted for payment, must be corrected. A copy of the program rejection notice must accompany the original claim. Corrections must be made on the original voucher (claim) if at all possible. If a new voucher is prepared, the original voucher must accompany the new claim form. Additional purchases will not be considered for payment on a resubmitted claim.

(D) Denied or rejected claims which do not meet the criteria in subparagraphs (B) or (C) of this paragraph may still be appealed through the program administrative review process or through the due process hearing procedure of the department.

(2) Claims with insurance coverage. Any health insurance policies that provide coverage to the applicant/patient must be utilized before the program can be of assistance. Providers must bill private or public insurance to determine the amount of coverage available prior to submitting any claim to the program for payment. The provider may bill the program if the purchase was authorized, and if the explanation of benefits (EOB) or the rejection letter is

attached to the voucher and is received by the program within 30 days of the date of the rejection, but no later than 180 days after the date of delivery of blood product.

(3) Required documentation. The program requires documentation of the delivery of goods from the provider.

(4) 90-day claims submission deadline. No claim may be considered for program payment if it reaches the program later than 90 calendar days after the date of delivery of blood product, except for claims involving third party reimbursement, as provided in § 37.121 of this title (relating to Payment of Services).

(5) Overpayments. Overpayments made in behalf of patients to providers must be reimbursed to the department by lump sum payment or, at the department's discretion, out of the current claims due to be paid the provider in behalf of patients. This will also apply to any person or persons who have a legal obligation to support the patient and have received third party or liability payments. The opportunity for an administrative hearing is available to providers and to the patient or person(s) responsible for the patient, as provided in § 37.124 of this title (relating to Appeals, Confidentiality, Gifts, and Nondiscrimination).

(6) Linkage with medically needy program. Patients eligible for both the program and the Medically Needy Program (MNP) through the Texas Department of Human Services (DHS) may submit unpaid claims used in meeting the MNP spend-down provision for payment consideration by the program if the claims were for program covered blood products provided no more than 30 days prior to the date the program received the patient's application. Claims must be submitted to the program after submission to the DHS' Medically Needy Program. The program may consider these claims for payment if funds are available and if the program receives within 30 days the claim returned by DHS. These are the only claims that the program may consider for payment without authorization.

§37.122. Payment Suspension or Cancellation.

The program may suspend or cancel payment for blood product purchases if false or fraudulent claims are submitted by a provider or supplier. Any provider failing to provide and maintain quality services or medically acceptable standards is subject to review, fraud referral, and/or administrative sanctions. Providers may request a due process hearing from the department.

§37.123. Cooperation with Other Agencies.

The department will cooperate with public agencies, federal, state, and local, and with private agencies and individuals interested in the welfare of persons with hemophilia. The program, as needed, will make every effort to establish cooperative agreements with other state agencies to define the responsibilities of each agency in relation to specific programs to avoid duplication of services.

§37.124. Appeals, Confidentiality, Gifts, and Nondiscrimination.

(a) Right of appeal. Any person aggrieved by a program decision to deny, modify, suspend, or terminate benefits or participation rights may appeal the decision in the following manner.

(1) Administrative review.

(A) Within 10 working days after receiving notice of denial, modification, suspension, or termination of benefits, a person aggrieved and wanting an administrative review shall respond to, or question, the program's decision and notify the program by certified mail of his/her request for an administrative review of the program's decision. Additional information bearing on the decision may be submitted at this time. Failure to request an administrative review within the 10-day period is deemed to be a waiver of the administrative review.

(B) Upon receipt of this response, a program administrative review team will affirm or reverse the proposed action, and respond in writing to the person, giving the reason(s) for the decision.

(C) Within 10 days after receiving written notice of the decision of the administrative review team, a person aggrieved by the program's administrative review may request a due process hearing from the department in accordance with the provisions of paragraph (2) of this subsection. A request for a hearing shall be sent to the program by certified mail. Failure to request the hearing within the 10-day period is deemed to be a waiver of the due process hearing.

(2) Due process hearing.

(A) The department will set a date and time at the Texas Department of Health in Austin, Texas, for the hearing.

(B) The hearing will not be conducted under the contested case provisions of the Administrative Procedure and Texas Register Act, but will include the following:

(i) timely written notice to the person aggrieved of the basis for the decision and disclosure of the evidence on which the decision is taken;

(ii) an opportunity for the person aggrieved to appear before an impartial decision maker to relate the basis for the decision;

(iii) an opportunity for the person aggrieved to be represented by counsel or another representative;

(iv) an opportunity for the person aggrieved or representatives to be heard in person, to call witnesses, and to present documentary evidence;

(v) an opportunity for the person aggrieved to cross-examine witnesses; and

(vi) a written decision by the impartial decision maker, setting forth the reasons for the decision and the evidence upon which the decision is based.

(b) Confidentiality of information. All medical records and other information maintained by the department which is confidential by law shall not be disclosed to the public.

(c) Gifts and donations. The department may receive gifts and donations in behalf of the program, which are deposited in the State Treasury and reappropriated to the program.

(d) Nondiscrimination statement. The Texas Department of Health operates in compliance with the Civil Rights Act of 1964 (Public Law 88-352, Title VI) and 45 Code of Federal Regulations Part 80, so that no person will be excluded from participation in, or otherwise subjected to discrimination on the grounds of race, color, or national origin.

§37.125. Income Guidelines.

The department adopts by reference the Annual Revision of the Poverty Income Guidelines published in the Federal Register, Volume 50, Number 46, dated Friday, March 8, 1985. A copy of the guidelines is indexed and filed in the Bureau of Crippled Children's Services, Texas Department of Health, 1101 East Anderson Lane, Austin, Texas, and is available for public inspection during regular working hours.